EXHIBIT 2

REPRESENTATIVE CASE SUMMARIES

1. *Christine A. Pane, etc., et al. vs. Actavis Totowa, LLC, et al.* (Decedent: Helen Gillmore);
2. *Dephlia Davis, et al. vs. Actavis Totowa, LLC, et al.* (Decedent: William Davis);
3. *Joseph L. Barrow et al. v. Actavis Group et al.* (Decedent: Sementra Barrow);
4. *William P. Metzler, Sr., etc. v. Actavis Group et al.* (Decedent: Marian Metzler);
5. *Erma Green, etc., et al. vs. Walgreen Co., et al.* (Decedent: Montez Green);
6. *Vicki Butts, etc., et al. vs. Actavis Totowa, LLC, et al.* (Decedent: Donald Earl Butts);
7. *Eva Weaver, etc., et al. vs. Mylan Pharm., Inc., et al.* (Decedent: Sarah Hood);
8. *Ginger King Edens, et al. vs. Mylan Pharm., Inc., et al.* (Decedent: Harry J. King);
9. *Alice L. Maroon vs. Actavis Totowa, LLC, et al.*;
10. *Eva Mae McCarty v. Actavis Totowa, LLC, et al.*;
11. *Arnold Newsome, et al. vs. Actavis Totowa, LLC, et al.*;
12. *Harold Collier, etc. v. Actavis Totowa, LLC, et al.* (Decedent: Karen S. Collier);
13. *Dorothy Rowsey, et al. vs. Actavis Totowa, LLC, et al.* (Decedent: James Edward Rowsey);
14. *Joseph M. Cavallaro vs. Actavis Totowa, LLC, et al.*;
15. *Rosemarie Bialynski, etc. v. Actavis Totowa, LLC et al.* (Decedent: Kenneth Bialynski);
16. *Bonnie Drexler-King, et al. vs. Actavis Totowa, LLC, et al.* (Decedent: Shirley Drexler); and
17. *Shirley Thomas, etc. v. Mylan Pharmaceuticals, Inc. et al.* (Decedent: Charles Thomas).

Christine A. Pane, etc., et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 08-1286

At age 83 Helen Gillmore's medical history was significant for atrial fibrillation, congestive heart failure, high blood pressure, diabetes mellitus, and kidney failure. In early 2008 she was taking digoxin 0.125 mg daily. On May 12, 2008 she presented to the hospital with a one day history of vomiting and diarrhea. She died in the hospital on the evening of May 12, 2008. According to her death certificate, her cause of death was hyperkalemia (elevated potassium levels) due to kidney failure and congestive heart failure.

Plaintiff claims that ingestion of adulterated digoxin caused Ms. Gillmore's death. There were no elevated SDCs measured in the months preceding Ms. Gillmore's death. On April 17, 2008, her SDC was 1.7 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the records provided or reviewed was Ms. Gillmore diagnosed with digoxin toxicity.

Dephlia Davis, et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 08-3173

At age 57 William Davis had a medical history significant for atrial fibrillation and severe dilated cardiomyopathy. His heart function was impaired, and his ejection fraction was approximately 25%, while a normal ejection fraction is greater than 50%. In early 2008 Mr. Davis was taking digoxin 0.375 mg daily. On May 3, 2008, Mr. Davis collapsed while making love to his wife. He was soon after declared dead. According to his death certificate, his cause of death was cardiac arrest caused by a heart attack.

Plaintiff claims that ingestion of adulterated digoxin caused Mr. Davis to experience a heart attack and die. There are no elevated SDCs in the months prior to Mr. Davis's death. The last SDC before Mr. Davis's death was drawn on August 6, 2007. His SDC that day was 0.4 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the records provided or reviewed was Mr. Davis diagnosed with digoxin toxicity.

Joseph L. Barrow et al. v. Actavis Group et al.
US District Court SD WV Case No.: 08-3699

Sementra Barrow, age 62 when she died, was first diagnosed with atrial fibrillation on September 28, 2007. At that time her medical diagnoses included hypertrophic cardiomyopathy and congestive heart failure. Ms. Barrow was admitted to the hospital from October 24, 2007 until November 3, 2007 with an episode of acute cholecystitis (gallbladder inflammation) requiring removal of the gallbladder. On October 30, 2007, during that admission, she was started on digoxin for rate control. She was discharged home on digoxin 0.25 mg daily. On November 12, 2007 she presented to the ER with a six day history of vomiting and shortness of breath. She was discharged home that day with instructions to follow-up with her regular physicians later that week. On November 14, 2007 Ms. Barrow died at home. An autopsy was performed, and according to her death certificate, her cause of death was a heart attack.

Plaintiffs alleges that ingestion of adulterated digoxin caused Ms. Barrow to experience various complications including her death. Ms. Barrow had no elevated SDCs prior to her death. Her SDCs were 0.6 ng/ml (normal 0.8-2.0 ng/ml) on November 3, 2007 and 1.9 ng/ml on November 12, 2007. Nowhere in the records provided or reviewed was Ms. Barrow diagnosed with digoxin toxicity.

William P. Metzler, Sr., etc. v. Actavis Group et al.
US District Court SD WV Case No.: 08-4863

At age 78 Marian Metzler's medical history included a heart attack, coronary artery bypass surgery, high blood pressure, and diabetes. In late 2007 she was taking digoxin 0.125 mg every other day. She was evaluated in the ER on November 19, 2007 after a fall out of bed. She was admitted to the hospital on January 1, 2008 after she was found on the floor by her bed. She was noted to be in atrial fibrillation with rapid ventricular response on admission. Ms. Metzler's digoxin was discontinued on January 7, 2008 when she was started on the medication amiodarone. During this admission she was also treated for a hip fracture. She was discharged to a nursing home on January 18, 2008. On February 27, 2008 she was evaluated in the ER for right arm pain and swelling; an ultrasound of the arm showed no evidence of a blood clot. She was discharged home from the nursing home on March 1, 2008. She died at home on March 2, 2008. According to her death certificate, her cause of death was complications of a hip fracture due to a fall.

Plaintiff alleges that ingestion of adulterated digoxin caused Ms. Metzler to experience a hip fracture, atrial fibrillation, and death. No SDCs were measured from November 2007 until Ms. Metzler's death. Nowhere in the records reviewed or provided was Ms. Metzler diagnosed with digoxin toxicity.

Erma Green, etc., et al. vs. Walgreen Co., et al.
US District Court SD WV Case No.: 09-00164

At age 80 Montez Green's medical history was significant for coronary artery disease, atrial fibrillation/flutter, congestive heart failure, chronic obstructive pulmonary disease, high blood pressure, and diabetes mellitus. In May 2008 she was taking digoxin 0.125 mg daily. Ms. Green was admitted to the hospital from May 4, 2008 until May 9, 2008 with an acute exacerbation of her congestive heart failure. She was discharged to a hospice facility and died on May 9, 2008. According to the death certificate, her cause of death was coronary artery disease.

Plaintiff alleges that ingestion of adulterated digoxin caused Montez Green to experience multiple complications, including her death. Ms. Green had a normal SDC measured at the time of her admission to the hospital. Her SDC on May 4, 2008 was 1.1 ng/ml (normal 0.8-2.5 ng/ml). Nowhere in the records provided or reviewed was Ms. Green diagnosed with digoxin toxicity.

Vicki Butts, etc., et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0193

Donald Earl Butts, 49 years old when he died, was first diagnosed with dilated cardiomyopathy after a viral infection in 2002. His viral cardiomyopathy resulted in impaired function of his heart; an echocardiogram from January 2007 measured his ejection fraction as 10-15%, while a normal ejection fraction is greater than 50%. He had additional medical conditions that included high blood pressure, diabetes, and congestive heart failure. In early 2007 Mr. Butts was taking digoxin 0.25 mg daily. He was admitted to the hospital from January 11, 2007 until January 13, 2007 with a congestive heart failure exacerbation. On January 26, 2007 he collapsed at home and was declared dead at the hospital. According to the death certificate, his cause of death was acute coronary syndrome due to cardiomyopathy.

Plaintiff claims that ingestion of adulterated digoxin caused Donald Earl Butts to experience multiple complications, including his death on January 26, 2007. Mr. Butts has two normal SDCs recorded in the weeks preceding his death. On January 9, 2007 his SDC was 1.0 ng/ml (normal 0.8-2.0 ng/ml), and on January 22, 2007 it was 0.9 ng/ml. Nowhere in the medical records provided or reviewed was Mr. Butts diagnosed with digoxin toxicity.

Eva Weaver, etc., et al. vs. Mylan Pharm., Inc., et al.
US District Court SD WV Case No.: 09-0224

At age 89 Sarah Hood had a history of atrial fibrillation, congestive heart failure, chronic renal disease, stroke, and high blood pressure. In April 2008 she was taking digoxin 0.125 mg every other day. She was admitted to the hospital on April 8, 2008 when she was found to have an ischemic right leg as well as end-stage cardiovascular disease. Her prognosis was poor, and on April 9, 2008 her family decided to discontinue aggressive therapy and continue only comfort measures. Ms. Hood died in the hospital on April 23, 2008. According to the death certificate, her immediate cause of death was end-stage cardiovascular disease.

Plaintiff alleges that ingestion of adulterated digoxin caused Ms. Hood's right leg ischemia and death. Ms. Hood had no recorded SDC elevations at that time. Her SDC on April 7, 2008 was 0.3 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the records provided or reviewed was Ms. Hood diagnosed with digoxin toxicity.

Ginger King Edens, et al. vs. Mylan Pharm., Inc., et al.
US District Court SD WV Case No.: 09-00230

In early April 2007 Harry J. King was 60 years old and had been diagnosed with lung cancer, coronary artery disease, and dilated cardiomyopathy requiring anticoagulation. He was taking digoxin 0.125 mg daily. Mr. King was admitted to the hospital from April 30, 2007 until May 2, 2007. During that admission he was diagnosed with a transient ischemic attack (TIA), an atrial thrombus, and a solid brain mass, later determined to be metastatic lung cancer. The atrial thrombus and TIA were attributed to a lapse in his anticoagulation. Over the next year Mr. King underwent radiation therapy and systemic chemotherapy for his cancer, had a heart attack, and underwent implantation of an internal defibrillator for a dangerous arrhythmia. He was admitted to the hospital on April 23, 2008 with a stroke that his cardiologist attributed to a left atrial thrombus. He died in the hospital on April 30, 2008.

Plaintiff alleges that ingestion of adulterated digoxin caused Mr. King's atrial thrombus, stroke, and death. Mr. King's SDCs were consistently non-elevated. His SDCs were 0.8 ng/ml (normal 0.8-2.0 ng/ml) on April 30, 2007, 1.0 ng/ml on February 16, 2008, 0.9 ng/ml on March 27, 2008, and 1.9 ng/ml on April 12, 2008. Nowhere in the records provided or reviewed was Mr. King diagnosed with digoxin toxicity.

Alice L. Maroon vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0235

At age 84 Alice Maroon has a medical history significant for symptomatic bradycardia that required pacemaker placement in 1997, paroxysmal atrial fibrillation since 2001, stroke in 2001, chronic obstructive pulmonary disease, and coronary artery disease. Prior and subsequent to the Digitek® recall she was taking digoxin 0.125 mg daily.

Ms. Maroon alleges that ingestion of adulterated digoxin has caused her to experience various symptoms including heart palpitations, atrial fibrillation, bradycardia, moderate to severe chest pain, shortness of breath, and fatigue. In the several years preceding the Digitek® recall, Ms. Maroon does not have any documented elevations of SDC. On March 1, 2006 her SDC was 0.6 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the records provided or reviewed has Ms. Maroon been diagnosed with digoxin toxicity.

Eva Mae McCarty v. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0237

At age 55 Eva Mae McCarty's medical history was significant for chronic atrial fibrillation, congestive heart failure, Pickwickian syndrome/obesity hypoventilation syndrome, organic heart disease related to obesity and obstructive sleep apnea, high blood pressure, and diabetes mellitus. Prior and subsequent to the Digitek® recall she was taking digoxin 0.25 mg daily. She was admitted to the hospital from May 24, 2008 until June 2, 2008 with decompensated congestive heart failure. She was continued on digoxin after her discharge.

Ms. McCarty alleges that ingestion of adulterated digoxin has caused her various complications including severe pain, mental anguish, and inability to walk without a walker. She did not have any elevated SDCs measured in the year prior to her hospitalization or during her hospitalization. Her SDCs were 1.9 ng/ml (normal for arrhythmia 1.5-2.0 ng/ml) on October 16, 2007 and 1.5 ng/ml (normal 0.8-2.0 ng/ml) on June 2, 2008. Nowhere in the records provided or reviewed was Ms. McCarty diagnosed with digoxin toxicity.

Arnold Newsome, et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-00239

At age 62 Arnold Newsome had a history of chronic atrial fibrillation, dilated cardiomyopathy, congestive heart failure, heart attack, and high blood pressure. In early 2008 he also had painful leg ulcers that caused him to take approximately 200 aspirin tablets during the first three weeks of March. He was also taking digoxin 0.25 mg daily at that time. On March 23, 2008 Mr. Newsome presented to the hospital with laboratory evidence of profound anemia and excessive anticoagulation therapy. Not long after his arrival at the hospital, he went into cardiac arrest and died. His death certificate lists his cause of death a gastrointestinal bleed, profound anemia, and coagulopathy secondary to Coumadin®.

Plaintiff alleges that ingestion of adulterated digoxin caused Mr. Newsome's death. Mr. Newsome's SDC was normal when he presented to the hospital. His SDC on March 23, 2008 was 1.1 ng/ml (normal 0.5-2.1 ng/ml). Nowhere in the records provided or reviewed was Mr. Newsome diagnosed with digoxin toxicity.

Harold Collier, etc. v. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0291

At age 57 Karen S. Collier's medical history was significant for chronic atrial fibrillation, congestive heart failure, pulmonary hypertension, bronchial asthma, and a mechanical aortic valve. In March 2008 she was taking digoxin 0.125 mg daily. She was admitted to the hospital on March 30, 2008 in atrial fibrillation with rapid ventricular response. She was administered intravenous digoxin after admission. Her condition deteriorated, and she declared dead on March 31, 2008. According to the death certificate, her cause of death was cardiogenic shock leading to cardiopulmonary arrest due to (1) respiratory failure secondary to chronic obstructive pulmonary disease and to (2) a non-ST elevation myocardial infarction.

Plaintiff alleges that ingestion of adulterated digoxin caused Ms. Collier's death on March 31, 2008. Ms. Collier had a normal SDC measured on March 30, 2008. Her SDC was 1.7 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the medical records provided or reviewed was Ms. Collier diagnosed with digoxin toxicity.

Dorothy Rowsey, et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0293

At age 82 James Edward Rowsey's medical history was significant for atrial fibrillation, congestive heart failure, diabetes mellitus, high blood pressure, and dementia. In early 2008 he was taking digoxin 0.125 mg daily. On March 24, 2008 he presented to the hospital with shortness of breath. He was admitted and remained inpatient until April 3, 2008. His digoxin was discontinued at discharge. He was readmitted to the hospital twice in April 2008; digoxin was not on his medication list during either hospitalization. He died on July 3, 2008. According to his death certificate, his cause of death was congestive heart failure.

Plaintiff claims that ingestion of adulterated digoxin caused Mr. Rowsey to experience multiple complications, including his death. Plaintiff alleges in the Plaintiff Fact Sheet that Mr. Rowsey first saw a health care provider in connection with his injuries on March 24, 2008. Mr. Rowsey had no elevated SDCs in the months leading up to his death. On March 24, 2008 his SDC was 0.4 ng/ml (normal 0.8-2.0 ng/ml). His digoxin was discontinued after that hospitalization. Nowhere in the records provided or reviewed was Mr. Rowsey diagnosed with digoxin toxicity.

Joseph M. Cavallaro vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0496

Joseph M. Cavallaro was 66 years old when he was first diagnosed with atrial fibrillation in May 2007. He was prescribed digoxin 0.25 mg daily starting in December 2007. His atrial fibrillation was paroxysmal as opposed to chronic, and his physicians ultimately decided not to continue him on anticoagulation therapy for prophylaxis against stroke. On April 21, 2008 Mr. Cavallaro experienced an acute loss of vision in his right eye. He was hospitalized from April 21, 2008 until April 27, 2008 for a right occipital lobe stroke.

Mr. Cavallaro claims that ingestion of adulterated digoxin was the cause of his stroke, which resulted in permanent partial blindness. He had a normal SDC documented at the time of his admission to the hospital. His SDC on April 21, 2008 was 0.8 ng/ml (normal 0.8-2.0 ng/ml). Nowhere in the medical records provided or reviewed was Mr. Cavallaro diagnosed with digoxin toxicity.

Rosemarie Bialynski, etc. v. Actavis Totowa, LLC et al.
US District Court SD WV Case No.: 09-00629

At age 66 Kenneth Bialynski's medical history was significant for a heart attack, congestive heart failure, dilated cardiomyopathy, diabetes mellitus, and renal insufficiency. His heart function was impaired, and his ejection fraction was approximately 25%, while a normal ejection fraction is greater than 50%. Mr. Bialynski was prescribed digoxin since at least 1999. In 2006 he was taking digoxin 0.125 mg daily. In April 2006 Mr. Bialynski twice refused to go to the hospital for further evaluation of his symptoms of increasing shortness of breath and fluid accumulation in the legs. According to Social Security death records, he died on December 12, 2006.

Plaintiff alleges that ingestion of adulterated digoxin caused Mr. Bialynski's death. Mr. Bialynski had no SDC elevations recorded starting in October 1999 until his death. He had no SDCs recorded in 2006. Nowhere in the records provided or reviewed was Mr. Bialynski diagnosed with digoxin toxicity.

Bonnie Drexler-King, et al. vs. Actavis Totowa, LLC, et al.
US District Court SD WV Case No.: 09-0641

Shirley Drexler was 72 years old when she suffered a stroke in May 2004. At that time she had a history of atrial fibrillation and high blood pressure. She was taking digoxin 0.125 mg daily prior to her stroke. She was hospitalized from May 2, 2004 to May 25, 2004. She received intravenous digoxin twice during her hospitalization and was discharged on a liquid digoxin formulation. Ms. Drexler died on February 15, 2006. Her death certificate attributed her death to her stroke years before.

Plaintiff alleges that ingestion of adulterated digoxin caused Ms. Drexler's stroke and subsequent death. None of the SDCs measured during the hospitalization for her stroke were elevated. Her SDCs were 0.7 ng/ml (normal 0.9-2.0 ng/ml) on May 2, 2004, 0.8 ng/ml on May 4, 2004, and 1.2 ng/ml on May 5, 2004. Nowhere in the records provided or reviewed was Ms. Drexler diagnosed with digoxin toxicity. At least one of her physicians attributed her stroke to inadequate anticoagulation therapy.

Shirley Thomas, etc. v. Mylan Pharmaceuticals, Inc. et al.
US District Court SD WV Case No.: 09-02059

At age 67 Charles Thomas had a history of heart attack, high blood pressure, high cholesterol, and diabetes. In early 2008 he was taking digoxin 0.25 mg daily. Mr. Thomas was evaluated in the ER on April 2, 2008 with complaints of abdominal pain. A CT scan of his abdomen revealed an abdominal mass that could have been a stomach tumor or a metastasis (spread of cancer from another cite). He was discharged home with pain medication and instructed to follow-up with his private physician. In the early morning hours of April 6, 2008, Mr. Thomas collapsed at home. He was declared dead shortly after his arrival at the ER. According to his death certificate, his cause of death was heart attack due to coronary artery disease and diabetes.

Plaintiff alleges that ingestion of adulterated digoxin caused Mr. Thomas's heart attack and death. The records from Mr. Thomas's hospital visits in April do not indicate any suspicion on the part of his providers that digoxin was the cause of his condition. No SDCs were checked. Nowhere in the records provided or reviewed was Mr. Thomas diagnosed with digoxin toxicity.